Patient Information

Please allow our staff to photocopy your driver's license and all available insurance cards.

Name: Gender: Home Phone:
Address:
City: State: Zip: Age:
Birth Date: Marital Status: S☐ M☐ W☐ D☐
Email: SS#
Employer: Occupation:
Years on Job: Name of Spouse,Parent or Guardian:
Birth Date:
How did you find out about our office?
Describe the major complaint that brings you to our office:

Is your condition due to an accident? Y ☐ N ☐ if so when?

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care pan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually). Appointments that are not cancelled at least 24 hours prior to their scheduled time are subject to a cancellation fee of $30.

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of an consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photo static copy of this agreement shall serve as the original.

Patient's Signature: ________________________________ Date: ___________

Spouse or Guardian's Signature: _______________________ Date: ___________

Case History

Please be sure to list all conditions or symptoms, both past and present. An understanding of your health history will help us to determine your appropriate care.

Name Date Age
Race Height Weight

Review of Systems

1. Do you have skin, hair or nail problems? Y☐N☐
2. Do you have mouth and/or throat problems? Y☐ N☐
3. Do you have nose and/or sinus problems? Y☐ N☐
4. Do you have ear problems? Y☐ N☐
5. Do you have eye problems? Y☐ N☐
6. Do you have chest or lung (breathing) problems? Y☐ N☐
7. Do you smoke? Y☐ N☐ Amount per day How long?
8. Do you have heart and/or blood pressure problems? Y☐ N☐
9. Do you have blood or lymph node problems? Y☐ N☐
10. Do you have digestive problems? Y☐ N☐
11. Do you have genital problems (prostate, vaginal, etc.) Y☐ N☐
12. Do you have urinary (kidney/bladder also) problems? Y☐ N☐
13. Females, have you had menstrual problems? Y☐ N☐
    Have you ever taken prescription birth control? Y☐ N☐
    Is there any chance that you are currently pregnant? Y☐ N☐
    Do you have any breast problems? Y☐ N☐
14. Do you have any nervous system diseases and/or mental health problems? Y☐ N☐
15. Do you have any gland and/or hormone problems? Y☐ N☐
16. Do you have allergy or immunity problems? Y☐ N☐
17. Do you have any muscle, tendon or ligament problems? Y☐ N☐
18. Do you have any bone or joint diseases (osteoporosis, arthritis, etc) Y☐ N☐

Past History

19. List any diseases which you've had in the past, including childhood diseases:

20. Tell us if you've ever been diagnosed with a particular condition such as diabetes, cancer, AIDS, etc.
21. Have you ever suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, or broken bones?

22. List all surgeries you've had (including tonsillitis, wisdom teeth, etc.)
    Date
    Date
    Date

Case History (continued)

23. Have you ever been hospitalized for any reason other than surgery? Y☐ N☐

24. Medications: Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis:

25. Your diet is: ☐ Balanced ☐ Fair ☐ Poor ☐ Excessive

Family History

26. Are there any diseases or conditions that are common among your family members? Y☐ N☐

Social History

27. In what position do you usually sleep, and how well?
28. Do you exercise on a regular basis? Y☐ N☐ How?
29. How do you spend your spare time (hobbies, etc)?
30. Do you use: ☐ Caffeine ☐ Tobacco ☐ Nicotine ☐ Recreational Drugs ☐ Alcohol
31. Please describe your work.
    Type: ☐ Professional ☐ Physical Labor ☐ Driver ☐ Clerical ☐ Homemaker
    Physical Demands: ☐ Heavy ☐ Moderate ☐ Mild ☐ Sedentary
    Stress Level: ☐ High ☐ Medium ☐ Low

Additional Questions

32. Do you have problems with recurring headaches? Y ☐ N☐ How often?

33. Are you losing weight without trying? Y☐ N☐
34. Does your pain wake you up at night? Y☐ N☐
35. Have you had a change in bowel or bladder activitiy? Y☐ N☐
36. Have you had a sore that doesn't heal? Y☐ N☐
37. Have you recently had unusual bleeding or discharge? Y☐ N☐
38. Do you have thickening/lump in the breast or elsewhere? Y☐ N☐
39. Do you have indigestion or difficulty swallowing? Y☐ N☐
40. Have you had an obvious change in a wart or mole? Y☐ N☐
41. Do you have a nagging cough or hoarseness? Y☐ N☐
42. In the space below, please explain or give additional details regarding the information you have given above, also any health history details that were not asked:

43. Who is your:
    Medical doctor? Dentist?
    OB/GYN?
    Other healthcare provider(s)

Complaint Form

Symptom #1:

On a scale from 1-10 with 10 being pain that makes you go to the emergency room and 1 being pain that is only slightly noticeable what number is your pain most of the time? 1-10 and at it's worst 1-10

What percentage of the time you are awake do you experience the above symptom?
☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-1005

When did this symptom begin?
What caused this symptom?
Did this symptom begin: ☐ Suddenly or ☐ Gradually

What makes the symptom worse?

What makes the symptom better?

How does the symptom feel? (sharp, dull, achey, burning, etc)
Does the symptom radiate to another part of your body? Y ☐ N ☐
If yes, where?
Is the symptom worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Symptom #2:

On a scale from 1-10 with 10 being pain that makes you go to the emergency room and 1 being pain that is only slightly noticeable what number is your pain most of the time? 1-10 and at it's worst 1-10

What percentage of the time you are awake do you experience the above symptom?
☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-1005

When did this symptom begin?
What caused this symptom?
Did this symptom begin: ☐ Suddenly or ☐ Gradually

What makes the symptom worse?

What makes the symptom better?

How does the symptom feel? (sharp, dull, achey, burning, etc)
Does the symptom radiate to another part of your body? Y ☐ N ☐
If yes, where?
Is the symptom worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Informed Consent

Patient Name: Date:

To the patient: Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment: As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, neuro tests, muscle strength tests, postural analysis, cold laser, hot/cold therapy, electrical muscle stimulation, kinesio tape, radiographic studies, mechanical traction, manual traction.

The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options. Other treatment options for your condition may include: • Self-administered, over-the-counter analgesics and rest • Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers • Hospitalization • Surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Dice, D.C. or Dr. Nall, D.C. and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Signature: ____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY. If you have any questions about the above notice, contact our Privacy Officer, Dr. Dice, D.C. at (919) 381-6960.

Our Obligations We are required by law to: • Maintain the privacy of protected health information • Give you the notice of your legal duties and privacy practices regarding health information about you • Follow the terms of our notice that is currently in effect.

How We May Use and Disclose Health Information Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law. To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.
Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.
Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.
National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.
Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.
Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.
Your Rights You have the following rights regarding Health Information we have about you:
Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.
Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.
Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.
Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your

request, in writing, to our Privacy Officer. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.
Changes to This Notice We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.
Complaints If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

Do we have your permission to mention to others you were in the office? (According to the HIPPAA guidelines, we cannot acknowledge you are in the building. May we tell someone who calls for you that you are here, for purposes of messages, picking you up)? ☐Y ☐N

Do we have permission to discuss your treatment or financial details with your spouse? ☐Y ☐N

Do we have permission to discuss your treatment or financial details with your direct family?
☐Y ☐N
Do we have permission to email you educational newsletters and send email & text appointment reminders?
☐Y ☐N

Do we have permission to send you emails regarding your home care (exercises, diet, supplements) or test results (x-ray, mri, lab work), if necessary? ☐Y ☐N

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Signature:__________________________________ Date:_______________

Parent or Legal Guardian’s signature:___________________________